STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING _____ B. WING _____	R-C 03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	1029 E 5TH ST CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00101614 completed on 1/20/12.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00102817.

Survey date: March 13, 2012

Facility number: 000316
Provider number: 155491
AIM number: 100286370

Survey team:
Barbara Gray RN TC
Sharon Lasher RN
Angel Tomlinson RN

Census bed type:
SNF/NF: 109
Total: 109

Census payor type:
Medicare: 18
Medicaid: 62
Other: 29
Total: 109

Sample: 5

Lincoln Centers For Rehabilitation and Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00101614.

Quality review 3/15/12 by Suzanne Williams, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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